DIOCESE OF PEORIA EMMAUS DAYS 2012 PERMISSION FORM FOR ADULTS

(This form is required for all participants.)

Session I: High School Graduates & College Aged
June 8-11, 2012 Nazareth House, Henry, IL

Session II: High School Juniors & Seniors
June 21-24, 2012, Nazareth House Henry, IL

Session III: High School Freshmen & Sophomores
July 8-11, 2012 St. Bede Abbey, Peru, IL

Session IV: 7th and 8th Graders
July 11-13, 2012, St. Bede Abbey, Peru, IL

PARTICIPANT INFORMATION

Participant Name:_____ Address:_____ _____ Phone Number: (_____)_____ E-mail Address:_____ (optional) Home Parish:_____	Session Attending (circle one): **I II III IV** Location (please check one): Nazareth House, Henry, IL_____ St. Bede Abbey, Peru, IL _____ Adult T-Shirt Size: (circle one) **S M L XL**
Date of Birth: _____ Grade Level for Fall 2011:_____	Participant Fees: $ _____$60.00_____ Parish Fees: $ _____$95.00_____ Pastor Signature:_____
Have you previously attended Emmaus Days? **Y N** If yes, what years? _____	**OFFICE USE ONLY** Parish Fee Paid _____ Participant Fee Paid _____

MEDICAL INFORMATION

PLEASE RETURN THE COMPLETED REGISTRATION FORM WITH ANY MONEY DUE NO LATER THAN TWO WEEKS PRIOR TO THE EMMAUS DAYS SESSION YOU PLAN TO ATTEND

MEDICAL INFORMATION

Does the participant have any known allergic reactions or chronic illnesses? □ Yes □ No

If yes, please describe: _____

Will the participant need to take any medication while on this trip? □ Yes □ No

If yes, list name of medication: _____

PARTICPANT MEDICAL INFORMATION & EMERGENCY FORM

Participant:

Name (first, middle, last): _____

Address: _____

Participant's Regular Physician:

Name (first, last): _____ Phone (including area code): _____

Medical Conditions:

Please list any medical conditions of the participant (asthma, diabetes, epilepsy, etc.): _____

_____

List any allergies or allergic reactions to medications of the participant: _____

_____

List any medications the participant is presently taking: _____

_____

Other pertinent medical information: _____

_____

Date of participant's most recent tetanus shot: _____

Medical Insurance Information:

Company: _____

Plan Number: _____ Employee Identification #: _____

Emergency contacts:

Name (first, middle, last): _____ Phone (including area code): _____

Relationship (friend, neighbor, coworker, etc.): _____

Other Contact

Name (first, middle, last): _____ Phone (including area code): _____

Relationship (friend, neighbor, coworker, etc.): _____

Authorization for Emergency Medical Treatment

This information will be kept in the possession of the Office of Vocations. A copy will be distributed to the person in charge of each Emmaus Days Session which the participant attends. Should the need arise this information will be given to the proper medical authorities.

I, _____ [the participant], understand that in the case of illness or injury, the Office of Vocations will try to notify the person I have listed above as an emergency contact. In case of medical emergency at a time when my listed emergency contact cannot be notified, I grant full power to the Office of Vocations to 1) arrange my transportation, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic; and 2) sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.

_____ _____

Printed Name of Participant Signature of Participant Date

STATE OF ILLINOIS)

) SS.

COUNTY OF_____)

SIGNED AND SEALED before me this _____day of _____, 20_____.

_____

Notary Public